



Oxford Health Plans








Member Enrollment and Physician Selection Form

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601 • 800-444-6222 • www.oxfordhealth.com

Thank you for choosing Oxford Health Plans as the health plan for you and your family.

IMPORTANT!

In order to process the attached Member Enrollment form and begin coverage, all of the following information must be completed accurately and in its entirety:

-  Date of Employment
-  Date of Marriage
-  Date of Birth
-  Social Security Numbers
-  Primary Care Physician selections
-  Information on other coverage that you or your spouse may have
-  Signature at the bottom of this form.

Note: Please press down firmly when completing this form.

If you have any questions, please feel free to call our Customer Service Department at 800-444-6222. Thank you for your cooperation.



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Please do not write in this area,
for Oxford use only.

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To Be Completed By EMPLOYER				(Please Print)			
NAME OF GROUP (EMPLOYER)		GROUP NUMBER		CONTRACT SPECIFIC PACKAGE (CSP)		BILLING GROUP (BG)	
EMPLOYEE'S EFFECTIVE DATE OF COVERAGE MO. DAY YEAR		IS INDIVIDUAL COVERED UNDER COBRA? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, QUALIFYING EVENT		DATE OF QUALIFYING EVENT	
PRODUCT SELECTED <input type="checkbox"/> HMO <input type="checkbox"/> Freedom <input type="checkbox"/> Liberty <input type="checkbox"/> Liberty HMO <input type="checkbox"/> Other:		IS EMPLOYEE CURRENTLY		ACTIVELY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		ON LEAVE OF ABSENCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
AVERAGE NO. OF HOURS WORKED PER WEEK		DATE OF FULL-TIME EMPLOYMENT MO. DAY YEAR		EMPLOYEE OCCUPATION		RETIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
EMPLOYER SIGNATURE				DATE MO. DAY YEAR			

To Be Completed By EMPLOYEE				(Please Print)			
LAST NAME		FIRST NAME & MI					
STREET ADDRESS		APT. NO.		HOME PHONE () ()		BUSINESS PHONE () ()	
CITY		STATE		ZIP		SOCIAL SECURITY NO	
						COUNTY	
						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
						BIRTH DATE MO. DAY YEAR	
OXFORD PRIMARY CARE PHYSICIAN		OXFORD CODE		IS THIS A NEW PHYSICIAN FOR YOU?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
OXFORD OB/GYN PROVIDER (Female Members)		OXFORD OB/GYN CODE		IS THIS A NEW PHYSICIAN FOR YOU?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
TYPE OF COVERAGE <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> PARENT / CHILD <input type="checkbox"/> HUSBAND / WIFE		ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME		SOCIAL SECURITY # OF POLICY HOLDER		COVERAGE DATE(S) / / TO / /	
LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> RUSSIAN <input type="checkbox"/> CHINESE <input type="checkbox"/> OTHER		COMMUNICATION PREFERENCE (PLEASE RANK IN ORDER FROM 1-4) _ MAIL _ FAX _ PHONE _ E-MAIL (ADDRESS		PREFERRED TIME/ PLACE OF CONTACT <input type="checkbox"/> DAY <input type="checkbox"/> EVENING <input type="checkbox"/> HOME <input type="checkbox"/> OFFICE			

EMPLOYEE'S Dependent Information				(Please Print)			
SPOUSE'S LAST NAME		FIRST NAME AND MI		BIRTH DATE		SOCIAL SECURITY NUMBER	
						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
DATE OF MARRIAGE / /		IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME		SOCIAL SECURITY # OF POLICY HOLDER	
						COVERAGE DATE(S) / / TO / /	
SPOUSE'S EMPLOYER		SPOUSE'S OCCUPATION		DAYTIME PHONE () ()			
OXFORD PRIMARY CARE PHYSICIAN		OXFORD CODE		IS THIS A NEW PHYSICIAN FOR YOU?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
OXFORD OB/GYN PROVIDER (Female Members)		OXFORD OB/GYN CODE		IS THIS A NEW PHYSICIAN FOR YOU?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
ELIGIBLE CHILD'S LAST NAME		FIRST NAME AND MI		BIRTH DATE		SOCIAL SECURITY NUMBER	
						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE		IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME		SOCIAL SECURITY # OF POLICY HOLDER	
						COVERAGE DATE(S) / / TO / /	
OXFORD PRIMARY CARE PHYSICIAN		OXFORD CODE		IS THIS A NEW PHYSICIAN FOR YOU?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
OXFORD OB/GYN PROVIDER (Female Members)		OXFORD OB/GYN CODE		IS THIS A NEW PHYSICIAN FOR YOU?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
ELIGIBLE CHILD'S LAST NAME		FIRST NAME AND MI		BIRTH DATE		SOCIAL SECURITY NUMBER	
						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE		IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME		SOCIAL SECURITY # OF POLICY HOLDER	
						COVERAGE DATE(S) / / TO / /	
OXFORD PRIMARY CARE PHYSICIAN		OXFORD CODE		IS THIS A NEW PHYSICIAN FOR YOU?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
OXFORD OB/GYN PROVIDER (Female Members)		OXFORD OB/GYN CODE		IS THIS A NEW PHYSICIAN FOR YOU?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
ELIGIBLE CHILD'S LAST NAME		FIRST NAME AND MI		BIRTH DATE		SOCIAL SECURITY NUMBER	
						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE		IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME		SOCIAL SECURITY # OF POLICY HOLDER	
						COVERAGE DATE(S) / / TO / /	
OXFORD PRIMARY CARE PHYSICIAN		OXFORD CODE		IS THIS A NEW PHYSICIAN FOR YOU?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
OXFORD OB/GYN PROVIDER (Female Members)		OXFORD OB/GYN CODE		IS THIS A NEW PHYSICIAN FOR YOU?		<input type="checkbox"/> YES <input type="checkbox"/> NO	

**If you have additional dependents, please use another enrollment form to provide the necessary information.
In order to help us quickly process this form and avoid delays, please make sure all areas are properly filled out.**

I authorize: deductions from my earnings for any required contributions; and all health professionals to provide Oxford Health Plans (Oxford), and its contracted professionals, information about health (including mental illness) care advice, treatment or supplies provided to me or my dependents relating to coverage for the purpose of coordinating patient care, evaluating and administering claims for benefits, and for fulfilling Oxford's obligations under state and federal law. Oxford may provide the plan with named above with benefit calculations used to pay claims for the review of the plan's experience and operation. **I will discuss any questions concerning the plan with Oxford's member services.** My signature below affirms eligibility for coverage, and that all information provided is full, complete and true to the best of my knowledge. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

EMPLOYEE/APPLICANT SIGNATURE		DATE
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Thank you for choosing an Oxford health care plan for your employees.

We want you to be aware of an important State of Connecticut legislation amendment regarding medical loss ratio. Public Act 09-46 changes the definition of the term and requires disclosure of medical loss ratio to insurance applicants.

As of October 1, 2009, health insurers are required to include a written notice of their medical loss ratio with each individual or group health insurance application for coverage, as reported in the last Consumer Report Card on Health Insurance Carriers in Connecticut.

Please share the following information with employees at the time of their application for Oxford coverage:

The medical loss ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut. It limits claims to medical expenses for services and supplies provided to members, excluding expenses for stop loss coverage, reinsurance, member educational programs, and other cost containment programs or features. The medical loss ratio for Oxford Health Plans (CT) for calendar year 2008 is 81.48 percent. The medical loss ratio for Oxford Health Insurance, Inc. is 83.1 percent.

Going forward, our Web site at www.oxfordhealth.com will be updated annually with our most current medical loss ratio information.

If you have questions regarding this new Public Act, please contact Oxford Client Services.

Sincerely,

Oxford